

IN THE MATTER OF THE APPLICATION REGARDING CONVERSION
OF PREMIER BLUE CROSS AND ITS AFFILIATES

Washington State Insurance Commissioner's Docket # G02-45

PRE-FILED DIRECT TESTIMONY OF:

E. Lewis Reid

March 31, 2004

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INTRODUCTION

Q. Please state your name.

A. My name is E. Lewis Reid.

Q. Please state your position and business address.

A. I am a retired attorney and foundation executive. My address is 6705 Stoetz Lane, Sebastopol, California 95472.

Q. What is the purpose of your testimony?

A. I have been retained as a consultant¹ by PREMERA, a Washington miscellaneous nonprofit corporation (“PREMERA”), Premera Blue Cross, a Washington nonprofit corporation (“PBC”), and certain of their affiliates (collectively “Premera”) to provide a reports to Premera in connection with Premera’s proposal to convert from nonprofit to for-profit status, and to create two Health Foundations (the “Washington Foundation” and the “Alaska Foundation,” collectively the “Health Foundations”) to serve unmet health needs in Washington and Alaska (the “Conversion Transaction”).

SUMMARY OF TESTIMONY

Q. Please summarize your opinions in this matter.

A. In my opinion, the proposed conversion of Premera from non-profit to for-profit serves the public interest. At the present time, the entire value of Premera is locked up in its taxable nonprofit corporate structure. When all of the initial stock of New PREMERA has been distributed to the two Health Foundations created in

¹ I have been retained solely as a consultant and am not acting as legal counsel for any party in this proceeding.

1 the conversion, Alaska and Washington will have two large philanthropic
2 organizations dedicated to improving health in those states.

3 Conversion to a for-profit stock company will enable Premera to escape
4 the double bind of being fully taxable, but having no access to investment capital.
5 Other Blue Cross and Blue Shield organizations around the United States have
6 preceded Premera on this road. One of the consequences of these conversions has
7 been the creation of a new and vigorous group of health philanthropies in
8 America. These philanthropies can address health needs of citizens that have
9 been ignored, or are not susceptible of being solved by government and the
10 existing health delivery system. This could never have been accomplished if the
11 Blue companies had remained in the unfavorable status of being taxable
12 nonprofits.

13 The mission of the Washington Foundation as set out in its proposed
14 Articles of Incorporation will enable it to address needs of the citizens of
15 Washington in a broad range of health related areas. The Washington Foundation
16 should be permitted to pursue that broad mission.

17 The single-tier structure proposed in the Amended Form A introduces
18 some additional complexity in the relations between the states of Washington and
19 Alaska. It also introduces some additional uncertainty in the ability of the
20 Foundation to be recognized as a section 501(c)(4) entity. That said, the single
21 tier is a feasible structure, with the additional benefit that, if realized, it will
22 permit the Washington Foundation to be free of excise tax on its investment
23 income in future years.

24 The independence of the Washington Foundation from New PREMERA
25 in the Amended Form A proposal should alleviate concerns about New
26 PREMERA control. Compensation of board members of the Foundation should

1 be permitted, as should expenditures other than grants to section 501(c)(3)
2 organizations. Otherwise the proposed provisions for governance of the
3 Washington Foundation should be acceptable.

4 The terms of the agreements that control the governance of New
5 PREMERA, and the divestiture of New PREMERA shares by the Health
6 Foundations, are reasonable and fair. The Blue Cross and Blue Shield
7 Association (“BCBSA”) restrictions, although they limit the rights of shareholders
8 in material respects, are ultimately in the interest of all parties – New PREMERA,
9 shareholders, the Health Foundations, and subscribers. Provided the leadership of
10 the Health Foundations and New PREMERA work together in good faith, there
11 should be no obstacles to an orderly monetization of their New PREMERA shares
12 and diversification of the investment of their endowments.

13 My opinions are based upon my background in creating, representing and
14 running charitable foundations. When I say that the Conversion Transaction is in
15 the public interest, I am speaking from the standpoint of the potential charitable
16 beneficiaries. The Amended Form A filing presents the Commissioner with the
17 opportunity to capture a massive benefit for residents of the State of Washington
18 in perpetuity. In my judgment, it would be tragic to forgo such an opportunity.

19 **Q. Have you submitted an expert report in this proceeding?**

20
21 A. Yes. My initial report (“Initial Report”) was filed November 10, 2003. I filed a
22 Supplemental Report on March 8, 2004, to comment upon the Premera proposal
23 as reflected in the amended Form A filed on February 5, 2004 and upon certain of
24 the matters and conclusions contained in reports filed by consultants engaged by
25 the staff of the Washington State Office of the Insurance Commissioner (the “OIC

1 Staff”). My Initial and Supplemental Reports are incorporated by reference into
2 this testimony.

3 QUALIFICATIONS

4 **Q. Please describe your experience with conversions of companies from**
5 **nonprofit to for-profit status and with charitable foundations.**

6 A. I was formerly President and CEO of The California Endowment, the largest
7 private foundation created in a Blue Cross or Blue Shield conversion. I retired from The
8 California Endowment in October 2000. I still serve on the board of directors of The
9 California Endowment.

Prior to joining The California Endowment in 1998 I was an attorney in San Francisco. My clients included the Alliance HealthCare Foundation, and the Sierra Health Foundation, both foundations created in the conversion of nonprofit health organizations to for-profit status. I was initially retained by the Sierra Health Foundation in Sacramento in the mid-1980s to be its outside counsel and to represent it in the monetization of the shares it received in a conversion transaction. The Alliance HealthCare Foundation in San Diego retained me in about 1990 to represent it in the conversion of San Diego's Community Care Network to for-profit status.

19 In early 1994 I was retained by Blue Cross of California to advise it on the
20 creation of a charitable foundation. When, in June of that year, the BCBSA
21 changed its rules to permit for-profit licensees, I began planning the structure of
22 the conversion of Blue Cross of California from nonprofit to for-profit status.
23 That process ended in May 1996 with the closing of the conversion transaction.

1 Two foundations were created in that conversion: California HealthCare
2 Foundation, a section 501(c)(4) organization that received the WellPoint stock
3 issued in the conversion; and The California Endowment, a section 501(c)(3)
4 private foundation that received \$900 million plus 80% of the proceeds of the
5 eventual sale of the WellPoint stock. When the conversion was completed, I
6 served as outside counsel to both foundations.

7 In 1998, I left law practice to lead The California Endowment. I retired
8 from The California Endowment in late 2000. I continue to serve on the board of
9 directors of The California Foundation. I also serve on the boards of the Larry L.
10 Hillblom Foundation, a private foundation dedicated primarily to medical
11 research on diabetes and neurodegenerative diseases, and the Buck Institute, a
12 research center conducting biomedical research and education on the aging
13 process and age-associated diseases.

14 **Q. Have you provided us with a resume?**

15 A. A true and correct copy of my resume is attached hereto as **Exhibit A** and
16 incorporated herein by reference; it will be marked as a Premera Hearing Exhibit.

17 **UNMET HEALTH NEEDS**

18 **Q. Have health care conversions in other states helped improve health in those**
19 **states?**

20
21 A. Yes. As a consequence of the health care conversions over the past fifteen years,
22 there has been a burst of new health philanthropy in the United States. By the end
23 of 2000 over 120 new foundations had been created in the conversion of nonprofit
24 entities to for-profit businesses. The health foundations created in the conversion

1 of Blue Cross/Blue Shield and other health care organizations to for-profit entities
2 have addressed needs in ways that are not customary for government or traditional
3 health insurers.

4 **Q. Please give some examples of those needs.**

5
6 A. I am aware from my experience first as legal counsel to and then as President and
7 CEO and a board member of The California Endowment that:

- 8 • Millions of our residents are uninsured;
- 9 • Only a fraction of the persons eligible for Medicaid coverage are enrolled;
- 10 • Only a fraction of the children eligible for federally funded CHIP
11 coverage are enrolled;
- 12 • Undocumented immigrants have health care needs but are largely left
13 outside our health care delivery system;
- 14 • The uninsured often use hospital emergency rooms as their primary care
15 resource, driving up the operating costs for hospitals in a particularly
16 inefficient allocation of resources;
- 17 • The safety net for the uninsured and particularly the community clinic
18 system are under dire economic stress;
- 19 • Financial support and technical assistance to community-based
20 organizations are needed to strengthen the safety net;
- 21 • Significant disparities in the health status of ethnic minorities exist,
22 particularly with respect to diseases such as diabetes and asthma;

- 1 • Community mental health systems are generally inadequate and under-
2 funded;
- 3 • Independent forums for convening all of the interested parties in our
4 health care systems need to be expanded;
- 5 • The demographics of our aging population will pose severe challenges to
6 our health systems in coming decades;
- 7 • Rising costs are limiting the availability of health care in rural areas, and
8 rural hospitals and clinics are under particular stress;
- 9 • Unhealthy behaviors such as smoking, bad diet, alcohol and drug
10 problems, lack of exercise, and unsafe sex severely degrade the health
11 status of our communities and impose massive health care costs on
12 society;
- 13 • Dental care is inadequate in many rural populations; and
- 14 • There is a need for more health care workers, especially nurses, and for
15 the health care work force to be more diverse.

16 All of these issues, and many more, are being addressed by the growth of
17 health philanthropy from conversions in other states. In California, for example,
18 The California Endowment received approximately \$3.0 billion in proceeds from
19 the conversion of Blue Cross of California. That endowment has enabled it to
20 make charitable distributions of \$150 million to \$200 million a year to address
21 problems such as those listed above. Even though we have gone through a severe
22 bear market in the past several years, The California Endowment's assets have

1 grown to \$3.5 billion while over \$1.0 billion has been distributed in charitable
2 grants and programs.

3
4 **CHARITABLE PROGRAMS OF**
5 **CALIFORNIA CONVERSION FOUNDATIONS**

6
7 **Q. Please give some examples of how foundations created through the**
8 **conversion of health care organizations have addressed these needs.**

9 A. In California the health of agricultural workers is a major concern. At The
10 California Endowment we commissioned a comprehensive study of their health
11 status. We learned that for the most part the workers are young men, many of
12 whom have left families behind in Mexico or Central America. Fewer than one-
13 third have any form of medical insurance, and only 7% are enrolled in any
14 government program that serves low-income people. Only one in six had any
15 form of health insurance provided by their employers. Nearly one-third of the
16 men said they had never been to a clinic or doctor's office; nearly half had never
17 been to a dentist.

18 One of our larger early initiatives was a \$20 million interest-free loan to
19 create a revolving loan fund to help fund farm worker health and housing projects.
20 These loan funds enabled communities to borrow over \$100 million in additional
21 construction funds. In each community in which housing was constructed there
22 were health facilities and programs funded by an additional \$11 million in grants.
23 The results in the affected communities were dramatic. In one community,
24 concern about dirt and garbage in the streets dropped from 89% before
25 construction to 11% after. Concerns about drug use dropped from 58% to 11%,
26 noise or trouble from drunks from 81% to 7%. Asthma is a significant problem in
27 these communities. Getting rid of mold, mildew and damp, pest-infested

1 conditions led to dramatic improvement in the respiratory health of both children
2 and adults.

3 The California Endowment has launched a \$50 million initiative to
4 improve the health of migrant workers. The first project under this initiative
5 funded 30 grantees. Many of these are working to bring dental health to farm
6 workers. Other activities include mental health services, mobile health units and
7 efforts to enroll agricultural workers in public health benefit programs. This
8 initiative also includes close work with the administration of Mexican President
9 Vicente Fox to try to find ways to provide health care for the workers and their
10 families on both sides of the border.

11 The health of Native Americans is also a significant challenge in
12 California. Many Native Americans live in rural areas where access to health
13 resources is tenuous. Recognizing the links between culture and health, The
14 California Endowment worked with the United Indian Health Services ("UIHS"),
15 an organization on California's North coast that serves nine tribes and more than
16 15,000 persons, primarily Yurok, Weeot and Tolowa Tribal members.

17 The California Endowment made a small planning grant to the UIHS.
18 When the planning was completed, we made a \$2.0 million seed money grant and
19 \$1.5 million matching grant to the UIHS to begin a fund for the creation of their
20 Potowat Health Village. These funds provided the core of fund raising efforts that
21 enabled the UIHS in 2001 to open a new state-of-the-art clinic and "health
22 village" on a 14-acre site on Highway 101 in Humboldt County. With The
23 California Endowment's grant in place, UIHS went on to obtain an additional
24 \$14.5 million in low-interest, long-term loans, grants and other donations needed
25 to fund the construction of a new health care facility and surrounding cultural
26 structures. The clinic provides primary medical and oral health services and

1 diabetic care, podiatry, mental health counseling and obstetrics. The community
2 also conducted extensive environmental restoration on the site, and has promoted
3 the health of residents through activities that emphasize traditional culture,
4 language, art and healing.

5 To address the problem of diabetes in Native American populations, The
6 California Endowment has made grants to the Northwest Portland Area Health
7 Board to build diabetes data collection and case management capacity in dozens
8 of Indian health centers around California. In another initiative, we have used
9 telemedicine to give diabetes patients at remote Indian health centers access to
10 skilled ophthalmologists.

11 One of the problems faced by hospitals in California, and I presume
12 elsewhere, is uninsured patients who use hospital emergency rooms as their
13 primary care option. Some of these, often from high-risk groups, such as the
14 homeless, substance abusers, or chronically and mentally ill, regularly arrive at
15 emergency rooms in crisis. The California Endowment and California
16 HealthCare Foundation are jointly addressing the problem of “frequent users,”
17 those who have serious health conditions and use health services in ways that
18 expend a disproportionate percentage of available health care resources. A pilot
19 model with 100 “frequent users” at a large urban public hospital was part of the
20 inspiration for this effort to create a number of planning and demonstration
21 projects. That project resulted in a 33% reduction in patient visits to the
22 emergency room, a 50% reduction in emergency room costs, and a 66% reduction
23 in inpatient costs. The two foundations have committed \$10 million to fund the
24 first five years of the initiative, with the understanding that success will create a
25 need for additional funding.

1 Over 500 community clinics in California provide health care regardless
2 of patients' insurance coverage or ability to pay. The community clinics in
3 California have been under economic stress for years. With declining
4 reimbursement rates for government-funded programs, and a large portion of their
5 patient base uninsured, it has been difficult for them to adapt. In its first four
6 years, The California Endowment granted over \$60 million to community clinics.
7 As an example, in 1999, responding to surveys the clinics identified their greatest
8 immediate needs as linked to the operational threats of Y2K. The California
9 Endowment through a fund we created at the Tides Foundation made a grant of
10 \$10 million to strengthen the information systems and management capacities of
11 community clinics to meet the Y2K crisis. The Endowment stepped in when other
12 potential funders backed off for fear that they might be held liable for Y2K
13 failures if they tried to help. The Y2K Emergency Response Fund provided grants
14 to 96 clinics and technical assistance to more than 300 clinics. The initial \$10
15 million grant was later augmented with another \$10 million for information
16 systems and training as well as inter-clinic coordination. The community clinic
17 system has been greatly strengthened through this program. Having worked with
18 the clinics on improving their computer technology capability, The California
19 Endowment/Tides Foundation partnership is now moving into capacity building,
20 including building the capability of the clinics to raise funds for capital
21 improvements.

22 One of the more difficult problems facing our health care systems today is
23 the acute shortage of qualified nurses, especially from ethnic minorities. The
24 problem is especially serious in the Central Valley. This agricultural valley has a
25 rapidly growing population with a large influx of Latinos and Southeast Asians,
26 and a ratio of registered nurses to population that is half the national average. To

1 address this issue, The California Endowment funded programs to increase the
2 size and diversity of the valley's nursing workforce, including scholarship
3 programs and funds to expand the capacity of the training programs that serve the
4 valley.

5 In addition to large programs such as those I have just described, The
6 California Endowment has made many hundreds of smaller grants to small
7 community-based nonprofit service providers.

8 **MISSION OF THE WASHINGTON FOUNDATION**
9

10 **Q. In your opinion, would the Washington Foundation be able to address**
11 **problems such as these?**

12
13 **A.** I understand that Premera has held a series of meetings with stakeholders and
14 community groups to hear what needs are most critical in the States of
15 Washington and Alaska. The purpose clause of the Washington Foundation's
16 Articles of Incorporation reflects the advice received in those meetings. As
17 drafted, the mission incorporates input from community organizations and targets
18 a wide range of health and health care issues. The overall purpose of the
19 Washington Foundation is "*to promote the health of the residents of the State of*
20 *Washington . . .*" It contemplates in subparagraph (a) that the Washington
21 Foundation will engage in "*health education and awareness,*" in (b) that the
22 programs will address both health care and "*related services,*" and in (f)
23 recognizes the importance of "*community based and culturally competent*
24 *programs . . .*" It also gives the Washington Foundation latitude to provide
25 "*grants*" and to establish "*programs.*" Language in the Transfer, Grant and

1 Loan Agreement that restricts expenditures to “grants” to “section 501(c)(3)”
2 entities should be reconciled with the Articles of Incorporation.

3 The Washington Foundation’s purpose implicitly addresses the issues of
4 behavioral and environmental determinants of health. This is important. Our
5 health does not depend solely upon the health care delivery system. Behavior and
6 environment are also critical. Unhealthy behaviors, such as smoking, bad diet,
7 alcohol and drug abuse, lack of exercise, and unsafe sex, harm our health and add
8 huge amounts to our health care costs. Environmental factors are contributing to
9 staggering levels of asthma in some minority populations. The mission is broad
10 enough to address all of the needs listed above.

11 Some argue that even large foundations have limited capacity when
12 compared with the overall health care budget of our society. That is true, but it
13 reflects a misunderstanding of the function, and potential, of charitable
14 foundations.

15 **Q. Do you believe that the Premera Conversion Transaction may have a similar**
16 **influence in Washington and Alaska?**

17
18 A. Yes. The foundations created by the Premera Conversion Transaction may not be
19 as large as The California Endowment. However, if the amount realized by the
20 Health Foundations were to be in the range of \$500 million to \$600 million, the
21 amount per capita available to health philanthropy in Washington and Alaska
22 would be roughly equivalent to that available in California from The California

1 Endowment, the largest foundation ever created in a Blue Cross/Blue Shield
2 conversion.²

3 The \$8 billion Robert Wood Johnson Foundation located in New Jersey is
4 the largest health-related private foundation in the country. It conducts health-
5 related charitable programs throughout the United States. By focusing their
6 efforts solely on Alaska and Washington, the Health Foundations can potentially
7 have a greater per capita influence on health in these two states than the Robert
8 Wood Johnson Foundation.³

9 If, as I understand some believe, the amount realized could be \$700
10 million or more, the per capita charitable endowment of the Washington and
11 Alaska foundations would be even more than that of The California Endowment
12 or the Robert Wood Johnson Foundation.

13 **Q. Is the structure of the proposed conversion in the public interest?**

14 A. Yes. The structure of the Proposed Transaction will maximize the potential
15 economic benefit to charities by providing transactional flexibility and by
16 minimizing the taxes incurred in the process of realizing the value of the initial
17 stock of New PREMERA issued to the Health Foundations.

18
19
20

SINGLE-TIER STRUCTURE

21 **Q. Is the single-tier structure proposed in the Amended Form A workable?**
22

² This statement is based upon the 2001 census, which reports that California's population is 34,501,130, Washington's population is 5,984,973 and Alaska's population is 634,892.

³ This statement is based upon the 2001 census, which reports that the population of the United States of America is 284,796,887.

1 A. Yes. The single-tier structure proposed in the Amended Form A, as contrasted
2 with the two-tier structure in the original Form A filing, introduces some
3 additional complexity in the relations between interests in the states of
4 Washington and Alaska. It also introduces some additional uncertainty in the
5 ability of the Washington Foundation to be recognized as a section 501(c)(4)
6 entity. That said, the single tier is a feasible structure, with the additional benefit
7 that, if realized, it will permit the Washington Foundation to be free of excise tax
8 on its investment income in future years.

9 **INDEPENDENCE OF THE WASHINGTON FOUNDATION**

10 **Q. Does the Washington Foundation retain sufficient independence from New**
11 **PREMERA?**

12
13 A. Yes. New PREMERA's right to observe the Washington Foundation's board
14 deliberations has been eliminated, and the initial post-closing board of directors
15 will be appointed by the Attorney General. The independence of the Washington
16 Foundation from New PREMERA in the Amended Form A proposal should
17 alleviate prior expressed concerns about New PREMERA control.

18 **GOVERNANCE OF THE WASHINGTON FOUNDATION**

19 **Q. Are the proposed provisions for governance of the Washington Foundation**
20 **sound?**

21
22 A. Yes, for the most part they are workable. The Articles of Incorporation and
23 Bylaws (with minor exceptions) are amendable only on a $\frac{3}{4}$ vote of the board of
24 directors and with the prior written approval of the Attorney General. Since these
25 documents will have been negotiated as an integral part of the transaction

1 documents, they should not be amendable by a bare majority of any future board
2 of directors.

3 The California Endowment has a similar restriction that prohibits
4 amendments of key provisions of its articles and bylaws without consent of the
5 Attorney General. On at least two occasions, there were critical issues that
6 required amendments. On those occasions the foundation sought, and obtained,
7 the Attorney General's consent. I would have been reluctant to seek the Attorney
8 General's approval for a request not backed by virtually unanimous support of the
9 board of directors. The high vote requirement should not be an impediment to
10 legitimate proposed amendments to the governing documents.

11 In my opinion, compensation of board members of the Foundation should
12 not be prohibited. Prohibiting board compensation is inconsistent with the
13 predominant practice in the health conversion foundations and, I believe, may
14 tend to screen out board members whose economic status would make it difficult
15 to commit time to service on the board without compensation. Properly
16 performed, board service on a large health foundation is hard work. It requires
17 commitment and concentration. Expectations of director performance should be
18 high. Prohibiting compensation will tend to encourage an elitist board of
19 directors. It will also tend to reduce the time and energy directors devote to the
20 board, shifting the locus of foundation policy from a broadly diverse board of
21 directors to foundation staff.

22 Under the current plan the Attorney General has the responsibility to
23 select both the "second" (pre-closing) and "third" (post closing) boards of

1 directors of the Washington Foundation. The Attorney General should conduct a
2 wide-ranging search to assure the appointment of a broadly representative, non-
3 political, diverse “third” board for the foundation.

4 Otherwise the proposed provisions for governance of the Washington
5 Foundation should be acceptable.

6 **FAIRNESS TO THE WASHINGTON FOUNDATION**

7

8 **Q. Are the terms of the proposed conversion fair to the Health Foundations?**

9

10 A. Yes. The terms of the agreements that control the governance of New
11 PREMERA, and the divestiture of New PREMERA shares by the Health
12 Foundations, are reasonable and fair. The BCBSA restrictions, although they
13 limit the rights of shareholders in material respects, are ultimately in the interest
14 of all parties – New PREMERA, shareholders, the Health Foundations, and
15 subscribers. Provided the leadership of the Health Foundations and New
16 PREMERA work together in good faith, there should be no obstacles to an
17 orderly monetization of their New PREMERA shares and diversification of the
18 investment of their endowments.

19 Cantilo argues that it is important for the Washington foundation to
20 nominate a second separate Designated Member to the New PREMERA board of
21 directors. Putting the Washington Foundation’s own Designated Member on the
22 New PREMERA board, rather than the single Designated Member, would not
23 further the larger objective of maximizing the funds available for health
24 philanthropy in Washington.

25 **Q. Are the agreements relating to the stock of New PREMERA unique?**

1 A. No. The agreements relating to the stock of New PREMERA are similar to those
2 customary in Blue Cross/Blue Shield conversion transactions. The Conversion
3 Transaction includes a series of agreements between and among New
4 PREMERA, the Health Foundations, a voting trustee, and the Health Foundations.
5 These include the Voting Trust and Divestiture Agreements, the Registration
6 Rights Agreement, the Excess Share Escrow Agent Agreement, the Guaranty
7 Agreements, the Transfer, Grant and Loan Agreement, the Unallocated Shares
8 Escrow Agent Agreement, and the BCBSA License Agreements. Many, but not
9 all, of the restrictions contained in these agreements flow from BCBSA conditions
10 for permitting BCBSA licenses to be held by for-profit corporations. Those
11 restrictions have appeared in one form or another in other Blue Cross/Blue Shield
12 conversion transactions.

13 **Q. Have similar restrictions created problems in other Blue Cross/Blue Shield**
14 **transactions?**

15
16 A. Similar, but in some cases more limiting, restrictions were contained in the Blue
17 Cross of California transaction and did not materially impede either the operations
18 of the foundations created in the transaction or the success in creating wealth for
19 the foundations by selling the WellPoint shares. In California, as the years after
20 the 1996 conversion of nonprofit Blue Cross of California into for-profit
21 WellPoint unfolded, none of these kinds of restrictions created significant
22 problems. Until the bulk of the WellPoint stock had been sold, former directors
23 of Blue Cross of California were required to hold the majority of seats on the
24 board of California HealthCare Foundation, the 501(c)(4) foundation that received

1 the initial WellPoint stock in the conversion. The foundation directors quickly
2 established themselves as independent of WellPoint and recognized that their
3 fiduciary duty was to California HealthCare Foundation. Most of the shares were
4 placed in a voting trust with terms similar to those found in the proposed
5 Conversion Transaction. Demand and “piggy back” stock registration rights were
6 governed by an agreement similar to the Registration Rights Agreement in the
7 Conversion Transaction. The disposition of the WellPoint stock held by the
8 foundation occurred smoothly over the first five years after the conversion was
9 closed. Today, none of the former Blue Cross of California directors remains on
10 the California HealthCare Foundation’s board. While the bulk of the stock
11 proceeds were transferred to The California Endowment, the California
12 HealthCare Foundation has assets of roughly \$750 million today.

13 **PRACTICALITY OF THE STOCK**
14 **DIVESTITURE REQUIREMENTS**
15

16 **Q. Are the requirements for divestiture of New PREMERA stock by the Health**
17 **Foundations practical?**

18 **A.** They are. Vesting New PREMERA shares in two Health Foundations, rather than
19 a single Foundation Shareholder, increases the complexity of managing the
20 divestiture. Now that each state will have a separate Health Foundation, the
21 consultants to the OIC urge that their shares should not be aggregated for the
22 purposes of meeting the divestiture schedule. If each of the Health Foundations
23 were permitted to comply separately with the BCBSA divestiture schedule, they
24 would be permitted to defer any sales for a number of years. However, without
25 selling stock, they will have no funds with which to conduct their charitable

1 activities. For that reason, they are likely to sell their stock before separate
2 divestiture schedules would require.

3 The allocation of shares between Washington and Alaska has not yet been
4 determined. It is my understanding that the Washington Foundation allocation
5 may be between 76% (the highest percentage recommended by the Alaska
6 consultants) and 82% (the lowest percentage recommended by the Washington
7 consultants). The allocation influences the time within which shares would have
8 to be sold under separate divestiture schedules. Under separate divestiture
9 requirements, as the initial size of the smaller allocation increases (and the larger
10 decreases), the potential for both Health Foundations to defer selling their stock
11 grows, and with it the risk of not achieving a healthy, orderly public market
12 increases. To put it another way, if the allocation were 95%/5%, separate
13 divestiture schedules would have virtually the same effect as a combined
14 schedule. As the allocations become closer to equal, separating the divestiture
15 requirements would significantly increase the theoretical potential for delay in the
16 creation of a vital market in the New PREMERA stock.

17 There is little doubt that, under the current Amended Form A structure, if
18 the directors of the Health Foundations are prudent in the diversification of assets,
19 they will have divested the New PREMERA stock long before the end of the ten-
20 year period. Under a disaggregated schedule, there is greater risk, but if the
21 Health Foundations respond appropriately to their needs to diversify assets and to
22 generate funds for their charitable activities, the relaxed divestiture requirement
23 may not have the adverse effect that it otherwise potentially could have.

24
25 **RECEIPT OF "FAIR MARKET VALUE"**
26

1 **Q. Will the restrictions contained in various agreements among and between**
2 **Premera and the Health Foundations prevent the Health Foundations from**
3 **receiving PREMERA's fair market value?**

4 A. No. While some argue that the restrictions will reduce the value of the shares,
5 such restrictions may actually increase the value of the shares to the Health
6 Foundations. Investors may react positively if the market in a stock is not too
7 volatile, if there is stable management, and if there is no threat of imprudent sales
8 of large blocks of shares that overhang the market. The Cantilo & Bennett
9 reports, however, ignore these possible benefits.

10 To some extent, the discussion of fair market value is a distraction.

11 Premera has no obligation to convert to for-profit status, and it acknowledges no
12 obligation to commit its assets to charity. Nevertheless, Premera proposes to
13 transfer 100% of the initial stock of New PREMERA to the Health Foundations
14 on the day the Conversion Transaction closes. At that time the Health
15 Foundations will own the entire business. The BCBSA license restrictions are
16 inherent in the business, inherent in operating as a licensee, and linked to the
17 commercial benefit of the right to use the name and mark. Even if there were a
18 charitable trust imposed on its assets (and there is not), Premera would not have
19 an obligation to transfer any more than the entire enterprise to charity.

20 Blackstone indicates that the OIC and its legal counsel have advised that
21 “an IPO conducted in a reasonable and customary manner could deliver fair
22 market value to the Washington Foundation.” In part, this conclusion is reached
23 because of provisions in the Amended Form A that a Pricing Committee of the
24 Board of New PREMERA will make the final pricing determination after
25 consultation with, and input from, Blackstone and other IPO Advisors. Also, the

1 Designated Member, chosen from candidates suggested by the Health
2 Foundations, must sit on the Pricing Committee for several years after closing. In
3 addition, the attorneys for the states of Alaska and Washington will be given
4 access to documents in order to review and comment on the information that will
5 be submitted to the SEC, investors or others as part of the Initial Public Offering.
6 These extensive and unusual protections should assure that the IPO will be
7 conducted in a way that benefits the Washington Foundation.

8 **Q. Does this conclude your direct testimony?**

9 **A. Yes.**

VERIFICATION

I, E. Lewis Reid, declare under penalty of perjury under the laws of the State of Washington that the foregoing answers are true and correct.

Dated this ____ day of March 2004, at _____, California.

/s/

E. LEWIS REID

Biographical Information – 2003

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Education:

- Princeton University, BSEE 1958
- Harvard Law School, LLB 1962

Professional Positions:

- (1962/1963) *University of California, Berkeley, School of Law*, Associate in Law
- (1963/1966) *Steinhart, Goldberg, Feigenbaum & Ladar, Attorneys*, Lawyer
- (1966/1968) *U.S. Senate Committee on Interior and Insular Affairs*, Minority Counsel
- (1969/1979) *Steinhart & Falconer, LLP, Attorneys*, Partner
- (1974/1978) *University of California, Berkeley, School of Law (Boalt Hall)*, Lecturer in Law
- (1979/1998) *Marron Reid, LLP, Attorneys*, Partner
- (1998/2000) *The California Endowment*, President and CEO
- (2000-present) *Civic and Corporate Activities*

Director, The California Endowment (*private foundation dedicated to improving the health of Californians*)

Director, Larry L. Hillblom Foundation (*private foundation dedicated primarily to biomedical research in the fields of diabetes and neurodegenerative diseases*)

Director, Sonoma Land Trust (*local community land preservation organization*)

Director, The American Trust for Wolfson College (Oxford) (*former Chairman and President*) (*US supporting organization to Wolfson College (Oxford)*)

Director, Buck Institute (*medical research institute conducting biomedical research and education on the aging process and age-associated diseases*)

Councilor, The American Land Conservancy (*national land preservation organization*)

Advisory Director, University of Southern California Center on Philanthropy and Public Policy (*Academic institute in the School of Public Policy and Planning at USC*)

Advisory Director, East Bay Regional Parks Botanic Garden (*California native plant botanic garden near Berkeley, California*)

Supernumerary Fellow, Wolfson College (Oxford) (1991-2003)

Director, Rinker Materials Corporation (1994-2003) (*Heavy building materials company*)